

CLAIM CORRECTION REQUEST FORM

Provider Name: _____
 AHCCCS Provider ID #: _____
 Provider Representative: _____

Please complete one request form for each Provider ID.

Recipient's name:		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

Recipient's name		Recipient's AHCCCS ID:		Dates of service:	Billed amount:
CRN:		Fields to be Changed / Comments / Questions:			

This is to certify the information submitted and changes listed/requested on this Claim Correction Request Form are true, accurate and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.		Date
Signature of Provider Representative (Required):		